



**EMERGENCY VEHICLE OPERATOR
COURSE AUTHORIZATION REQUEST**
NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF EMERGENCY MEDICAL SERVICES
SFN 53359 (9-03)



Telephone (701) 328 - 2388 / Fax (701) 328-1890

INSTRUCTIONS: Type or print clearly. Return one completed copy **2 WEEKS BEFORE COURSE BEGINS** to: ND Department of Health, Division of Emergency Medical Services, 600 E Boulevard Ave. Dept. 301, Bismarck, ND 58505 – 0200.

Keep a copy for your records.

TYPE OF TRAINING (Please check one or both)

<input type="checkbox"/> Initial and / or	<input type="checkbox"/> Refresher
The course will be conducted at: (Name of Facility)	City:

THE CLASS WILL BE CONDUCTED BY (check one – provided name and address)

<input type="checkbox"/> Name of EMS Service	Facility:			
	Address:	City:	State:	Zip:
<input type="checkbox"/> Facility name / Organization	Facility:			
	Address:	City:	State:	Zip:
<input type="checkbox"/> Other	Facility:			
	Address:	City:	State:	Zip:
The course will begin on: (Approximate date)		The course will end on: (Approximate date)		
The course will meet: (i.e. every Tuesday, every Tuesday and Thursday etc.)		Meeting time: (Approximate time)		
EVO Instructor: (Name)		Email Address: (Optional)		
Mailing Address:		City:	State:	Zip:
UPS Delivery Address: (If different from above)		City:	State:	Zip:
Work Telephone:	Home Telephone:	Cell Telephone:	Fax Telephone:	

As EVO Instructor, I will secure course materials and visual aids, secure use of classroom and practical facilities, prepare and implement class schedules, and perform other appropriate class functions. I will adhere to the Emergency Vehicle Operator-Ambulance National Standard Curriculum throughout the course.

Date:	Signature:
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<u>DEMS USE ONLY</u>	
Posted on Website _____ By _____	Course Authorization # _____